



August 17, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5540-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Request for Information; Episode-based Payment Model [CMS-5540-NC]

Dear CMS Officials,

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer comments on the proposed rule entitled "Request for Information; Episode-Based Payment Model" that was published on July 18, 2023.

ASHA is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology assistants, and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiology treatment, including hearing aids. Speech-language pathologists (SLPs) identify, assess, and treat speech, language, swallowing, and cognitive-communication disorders.

ASHA applauds the Innovation Center's vision of having a health care system that achieves equitable outcomes through high quality, affordable, person-centered care. As non-physician qualified health providers, audiologists and SLPs have had limited opportunity to participate in alternative payment models and other value-based care initiatives to date. We are eager to engage with the Innovation Center to explore, refine, and develop models that create an avenue for non-physician qualified health provider participation.

Care Delivery and Incentive Structure Alignment

How can CMS support providers who may be required to participate in this episode-based payment model?

Because the vast majority of audiologists and SLPs operate under fee-for-service models, many are unfamiliar with or unaccustomed to alternative payment models such as episode-based payment models. CMS can support providers through initial investments of capital to establish the technological and care coordination equipment and processes essential to success in value-based care. Alternatively, a ramp up period in which providers can participate in upside-risk-only arrangements would encourage new providers to explore value-based care in a financially responsible way prior to transitioning to full-risk arrangements.

ASHA encourages CMS to consider how they can develop episodic models that incorporate all members of multidisciplinary care teams which could be expanded existing models, including the applicable quality metrics, or developing new models focused on non-physician practitioners. As currently structured, many of the approved models are physician-driven and focused on the entire episode of care. The quality measures often do not capture the services of non-physicians such as audiologists and SLPs, and, therefore, there is no incentive for physicians to incorporate these specialties into the model. Audiologists and SLPs are also not responsible for managing the full range of services a patient may need but could be held accountable for the cost of care associated with the types of communication interventions they provide. We hope CMS will consider if they can develop models that capture the quality and cost associated with non-physician services to ensure it is achieving its goal of improving the quality of care patients receive and protecting the Medicare trust fund.

Clinical Episodes

Should CMS test new clinical episode categories?

ASHA is interested in exploring episode-based payment models that will allow audiologists and SLPs to fully participate in the transition from fee-for-service to value-based care. Inclusion of audiologists and SLPs in these models to date has been extremely limited. Audiologists are integral members of clinical teams involved in episodes relating to dementia, craniofacial surgery, cytomegalovirus, acquired brain injury, hearing loss, and vertigo, among others. Speech-language pathologists are members of interprofessional collaborative teams addressing a variety of illnesses and injuries including, but not limited to, acquired brain injury, aerodigestive disorders, head and neck cancer, dementia, craniofacial disorders, and developmental disabilities. Any of these conditions require the knowledge and skills of a range of health providers for effective management. These examples would lend themselves well to a new clinical episode to expand opportunities for non-physician providers.

We believe any new clinical episode categories should include all members of the care team and ensure equitable distribution of incentive payments. Health system transformation can best be achieved through incentives for all health care providers, not exclusively primary care or specialty physicians.

Health Equity

Should episode-based payment models employ special adjustments or flexibilities for disproportionate share hospitals, providers serving a greater proportion of dually eligible beneficiaries, and/or providers in regions identified with a high ADI, SVI, or SDI?

ASHA supports health equity adjustments because it allows providers to demonstrate quality care to all patients, including those who are dually eligible for Medicare and Medicaid. Economic instability is one of many social determinants of health (SDOH)—or the nonmedical factors such as where people are born, live, learn, work, play, worship, and age—that affect a wide range of health, functioning, and quality-of-life outcomes and risks. In a value-based payment system, identification of and payment adjustment for SDOH are

essential because patients with fewer SDOH risk factors become more “attractive” to providers since they will likely have better outcomes and require fewer services and resources as compared to their “riskier” counterparts, despite similar clinical characteristics.

Cherry picking refers to carefully selecting a caseload of the mostly healthy, uncomplicated patients who are the more likely to have good outcomes with the least amount of intervention; thereby, making these patients a “low” financial risk and “high” payment opportunity. Conversely, lemon dropping occurs when providers are disincentivized from treating patients with one or more SDOH risk factors such as economic instability and lack of access to education and quality health care—including preventative care—leading to chronic conditions, multiple comorbidities, and disabilities in underserved populations. Such patients often require more services, are challenging to manage clinically, require a longer length of stay, and might be more costly. Their risk factors may incorrectly skew a facility’s quality scores or measure denominators when these patients are excluded from the measure.

Without health equity payment adjustments, value-based systems inadvertently incentivize cherry picking and lemon dropping, which leaves the most vulnerable patients without adequate access to care and exacerbates the health disparities common under a fee-for-service payment model.¹ ASHA supports health equity adjustment methodology that incentivizes the care of dual eligible patients without penalizing skilled nursing facilities (SNFs) who are not yet able to meet the 20% threshold during this period.

Quality Measures and Multi-Payer Alignment

Which quality measures, currently used in established models or quality reporting programs, would be most valuable for use across care settings?

CMS reports that thus far, episode-based payment models have demonstrated reductions in spending, largely driven by reductions in post-acute care (PAC) spending or utilization, with minimal to no change in quality of care. Current outcome and quality measures, such as PSI 90, are understandably focused on inpatient safety and quality. As models grow from inpatient only to post-acute and outpatient settings, ASHA encourages the Innovation Center to develop outcome measures that take into account all functional domains including communication and cognition. The Functional Discharge Score finalized for the skilled nursing facility quality reporting program (SNF QRP) and proposed in the 2024 Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule and the 2024 Home Health Prospective Payment System Proposed Rule attempts to capture such outcomes. However, a complete assessment of holistic functions that goes beyond mobility and self-care will more accurately capture the outcomes required for safety and independence. We remain committed to assisting CMS inaccurately assessing all domains of function to accurately capture patient outcomes, quality of life, and independence.

Payment Methodology and Structure

What risk factors, including clinical or social, should be considered?

In addition to clinical severity and comorbidities captured in existing payment systems (PDPM, PDGM), SDOH should factor into payment calculations in the form of risk adjustment. Healthy People 2030 groups SDOH into five subgroups: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. As discussed above, value-based payment systems that exclude non-medical factors in payment risk exacerbating existing health inequities.

Thank you for considering ASHA's comments. If you or your staff have any questions, please contact Rebecca Bowen, MA, CCC-SLP, PNAP, ASHA's director for health care policy for value and innovation at rbowen@asha.org.

Sincerely,

A handwritten signature in black ink that reads "Robert M. Augustine". The signature is written in a cursive, flowing style.

Robert M. Augustine, PhD, CCC-SLP
2023 ASHA President

¹ Navathe, A.S, Liao JM. Aligning Value-Based Payments With Health Equity: A Framework for Reforming Payment Reforms. *JAMA*. 2022;328(10):925–926. doi:10.1001/jama.2022.14606.